Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: HILL COUNTRY BEHAVIORAL HEALTH P O BOX 600324 DALLAS, TX. 75360	MFDR Tracking #: M4-04-4279-02 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO. Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Pre-Auth. #LVG11184P" and "Pre-Auth. #12272P"

Principle Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Pre-Authorization Letter
6. Total Amount Sought - $1480.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…This treatment was preauthorized based on medical necessity alone. In fact, as a courtesy the preauthorization reply referred to the compensability issue."

Principle Documentation:

1. Response Package
2. Pre-Authorization Letter
3. TWCC-21 form

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12-10-02	90844 90889 (15 mins.)	Not Timely Filed	$122.00 $30.00	$0.00 $0.00
12-18-02	90844 90889 (15 mins.)	N/A	$122.00 $30.00	$0.00 $0.00
1-8-03	90844 90889 (30 mins.)	N/A	$122.00 $30.00	$0.00 $0.00
1-13-03 1-20-03	90844 90889 (60 mins.) 90900 (60 mins.) 90906 (60 mins.) 90915 (60 mins.)	N/A	$122.00 $30.00 $120.00 $120.00 $120.00	$0.00 $0.00 $0.00 $0.00 $0.00
		Total Due:		$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.201;1996 Medical Fee Guideline sets out the reimbursement of workers' compensation codes provided on or after April 1, 1996.
3. The services in dispute were denied by the respondent with the following reason codes:

   Explanation of benefits dated January and February 2003:

   - R – Extent of Injury
   - RA – The treatment/service has been determined to be unrelated to the extent of injury-final adjudication has not taken place on this issue
   - YR – The treatment/service has been determined to be unrelated to the extent of injury-final adjudication has not taken place on this issue

   Explanation of benefits dated February 2003:

   - D – Duplicate bill
   - 60 – The provider has billed for the exact services on a previous bill

Issues

1. Has final adjudication occurred and has compensability now been established and/or resolved ?
2. Were the disputed services performed to the accepted, compensable worker's compensation injury(s) ?
3. Is the requestor entitled to reimbursement?

Findings

1. Per the most recent TWCC-21 form filed on April 29, 2004, the carrier accepted that the compensable injury was limited to a cervical and lumbar sprain/strain, right shoulder, and right elbow. The carrier disputed disc protrusions and herniations at C2-3, C3-4, C4-5, C6-7, and L5-S1 as well as disc desiccation at L4-5. Per a Contested Case Hearing (CCH) conducted on March 16, 2005 it was determined that the claimant did sustain a compensable injury; however, it did not extend to include herniations at C3-4, C4-5, C5-6, or L5-S1. This decision was appealed; however, the decision was upheld by the appeals panel.
2. A review of the CMS 1500 forms identify that the Requestor billed with the diagnosis codes of 722.91 (other and unspecified disc disorder of cervical region), 722.93 (other and unspecified disc disorder of lumbar region), and 719.42 (pain in joint, upper arm). The 'disc disorders' of the cervical and lumbar regions were deemed as non-compensable at the CCH and therefore payment cannot be recommended.
3. MDR (Medical Dispute Resolution) received this medical dispute on December 11, 2003. Pursuant to Rule 133.307, the Requestor has one year from the date of service in which to file their dispute with MDR. The disputed DOS of 12-10-02 was not timely filed in accordance with Rule 133.307.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	**4-12-10** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.